Connecticut Community KidCare

PRACTICE STANDARDS

for

Emergency Mobile Services (EMS)

Connecticut Department of Children and Families
Mental Health Division

Approved by the Children's Behavioral Health Advisory Committee on June 6, 2003

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BACKGROUND

Emergency Mobile Services ("EMS")* are core services of Connecticut Community KidCare. The Governing body of KidCare is the "Behavioral Health Partnership". In August 2001, the Department of Children and Families (DCF), the Department of Mental Health and Addiction Services (DMHAS), and the Department of Social Services (DSS) formed the Connecticut Behavioral Health Partnership (Partnership) to plan and implement an integrated system for financing and delivering public behavioral health services and programs for children and adults. The primary goal of the Partnership is to provide access to a more complete, coordinated and effective system of community-based behavioral health services and supports. The Departments are committed to making enhancements to the current system of care in order to improve access, quality, and individual outcomes. The child service system initiative under the Partnership is referred to as Connecticut Community KidCare, while the adult initiative is referred to as the Recovery Healthcare Plan for Adults. KidCare services for children emphasize early intervention through the opportunities to access an array of culturally competent, quality services. Services are intended to be flexible and responsive to the needs of children and their families and may be delivered in the home or in the community.

The Department of Children and Families holds statutory responsibility for Connecticut's mental health services to children. DCF recognizes that certain components of treatment services may require additional guidelines over and above the requirements of licensing and regulation. Consequently, the Department, in collaboration with providers and families, develops certain "Practice Standards" as expectations of the programs from which it purchases services. Practice Standards are submitted to the statewide Children's Behavioral Health Advisory Committee (CBHAC) for review and approval. After CBHAC approves practice standards, they are submitted to the Commissioner of DCF for final approval.

Practice Standards are <u>not</u> equivalent to licensing or regulation requirements, but instead delineate certain specific expectations of services purchased by DCF through contract or agreement. In short, they are the articulation of *best or preferred practices* as agreed upon by the purchasers, providers, and consumers of services. Practice Standards compile information and establish standards reflecting diverse contributions based on a current understanding of effective emergency and crisis service provision to children, youth, and their families. It is the intention of DCF to periodically review and update these Practice Standards in order to reflect both the needs of DCF and accepted contemporary views regarding the effective provision of Emergency Mobile Services.

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* Emergency Mobile Services are sometimes referred to as Emergency Mobile Psychiatric Services. The EMS term is preferred because it addresses the spectrum of Behavioral Health issues, including both Substance Abuse and Psychiatric.

SYSTEMS OF CARE CORE VALUES AND PRINCIPLES

All treatment, support, and care services must be provided in a context that meets the child's psychosocial, developmental, educational, treatment and care needs. Successful intervention with this population requires an atmosphere that encourages normal development; is in the least restrictive environment necessary; fosters respect for others; and is nonjudgmental. A child's family must also be provided continuing encouragement to engage as full partners in all aspects of their child's treatment, treatment planning and the decisions that are made.

EMS and all KidCare services are embedded in the system of care philosophy that has been promulgated by the federal Center for Mental Health Services and implemented throughout the country. The most distinguishing aspects of the System of Care model are its Values and Principles.

Core Values

1.C*are for children must be child-centered while being family focused, with the needs of the child and family dictating the types and mix of services to be provided.*

2.To the degree it can be safely achieved, *services should be community-based; or a plan shall be in place for step-down to community-based services*. In doing so, the locus of services as well as management and decision-making responsibility should rest in partnership with the family and child, other community providers, educational representatives, other community support and the current treatment provider. When out-of-community services such as residential care are necessary, treatment planning must focus on safely integrating and returning the child to the community setting.

3. *The system of care should be culturally competent, with agencies programs and services that are responsive to the cultural, racial, and ethnic differences of the populations served.*

Guiding Principles

- Children and adolescents should have access to a comprehensive array of services that address the child's physical, emotional, developmental, social, and educational needs.

- Children and adolescents should receive individualized services in accordance with the unique needs and potentials of each child, and guided by an individualized service plan.

- Children and adolescents should receive services within the least restrictive, most normative environment that is clinically appropriate.

- The families and surrogate families of children and adolescents should be full participants in all aspects of the planning and delivery of services.

- Children and adolescents should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing, and coordinating services.

- Children and adolescents should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of services in accordance with their changing needs.

- Early identification and intervention for children and adolescents with emotional and behavioral difficulties should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

- Children and adolescents should be ensured smooth transitions to the adult service system as they reach maturity.

- The rights of children and adolescents should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.

- Children and adolescents should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

DEFINITIONS OF TERMS USED

a. "Emergency Mobile Services"

Emergency Mobile Services are community based programs intended to provide early intervention in response to crises; clinical assessments in locations of parental preference; and stabilization services to prevent unnecessary placements into hospitals, emergency departments or residential facilities; and rapid triage into supervised, structured settings for those youth whose clinical conditions require a higher level of care. The service is available by telephone 7 days a week, 24 hours a day.

b. "Emergency"

Emergency depicts a situation requiring *immediate action.* Because different parties assess situations differently, EMS teams should initially view all case presentations to EMS as needing immediate action until further information is obtained to determine otherwise. In other words, the EMS clinician should err on side of accepting that the situation is a crisis warranting intervention by EMS.

c. "Mobile"

Mobile means that the EMS staff is expected to go into the community, whether that is the family's home or an alternative community site of the family's preference. The reasons why an EMS team or clinician would not be mobile are as follows:

- The individual or family affirmatively *chooses* to come to the clinician's office.
- The clinical staff assess the safety of the EMS team would be in jeopardy and adequate security cannot be maintained.
- The clinician assesses the situation as needing a more intensively supervised, structured setting, e.g. a hospital emergency department.

Mobile interventions will always be in person. But in-person interventions are not always "mobile". If the family explicitly prefers to come to the clinic office or another location other than their home, the in-person intervention would not have to be in the family's residence.

d. "At Risk"

At risk describes a situation that poses potential for physical harm to self or others, psychological trauma to self or others, and other matters of grave concern that are present or that have the potential to change at any given time and increase in severity. In the context of EMS, "at risk" refers to the clinical and environmental situation of the child and family.

e. "Imminent Danger"

Imminent danger means that *without immediate intervention the child/youth, and caregivers' safety, is at serious risk.* It involves the possibility of a lethal plan means to

carry out that plan. In this scenario, it is expected that the clinician will take steps to keep the child/youth and other parties safe and curtail or remove aspects of the situation that pose a danger.

f. "Crisis Plan"

Crisis plan identifies steps, which are known to all parties involved and which are explicitly given to parents and determined with their input, that will be followed in the crisis situation. The Plan should be very detailed as to *how, what, when, and with whom* the child/youth and involved parties should behave if/when the situation escalates. This would include persons to be called, telephone numbers, actions to be taken, etc. The Crisis Plan also includes continuing assessment and stabilization services if the situation does *not* escalate.

g. "Engagement"

EMS clinicians shall seek to develop a partnership with families in a manner that is consistent with system of care values and principles. It's crucial to engage with the family in a way that respects cultural differences and parental preferences. However, engagement should not lead to dependency or in-depth therapeutic relationships.

h. "Target Population"

Children (under the age of eighteen) and their families, who believe that circumstances related to an emotional or behavioral crisis are sufficiently critical to require intervention and/or which will escalate without intervention. Those children and their families believe they are unable to resolve matters on their own at the time they seek services nor can they wait for routine outpatient support. All children and families in Connecticut are eligible for EMS service if an emotional or behavioral crisis is present.

i. " Emotional or Behavioral Crisis"

This is defined largely by the judgment of the person requesting help, who believes circumstances are unsafe and the situation will escalate without intervention, and the believes they are unable to resolve matters on his or her own.

j. "Clinical Intervention"

Services must be coordinated with the local system of care and provided in a manner consistent with System of Care values. The following program components must be in place:

- 24 hour a day, 7 day a week telephone availability for clinical assessment and crisis intervention. This includes telephone assessments outside of the posted hours of the program. At a minimum, EMS is available to conduct off-site, in-person assessments and stabilization between the hours of 10:00 a.m. and 7:00 p.m. on weekdays and between 1:00 p.m. and 7:00 p.m. on Saturdays, Sundays, and national holidays.
- Mobile clinical assessment and intervention services, including both in-home and out-of-home options based on clients' needs and preferences; and including psychiatric consultation by telephone and psychiatric evaluation in person where these capabilities are built into the contract with DCF. Clear protocols guide

program staff and subcontractors regarding the triage of telephone calls and the decision that a caller needs *information and referral* versus *clinical intervention*

Clear protocols guide the clinicians to determine in a consistent way around the state (in adherence to these Practice Standards) whether the clinical intervention will be solely over the phone or involve in-person assessment and stabilization, as well as the site of any in-person interventions.

Follow-up stabilization services for up to six weeks after the initial contact including but not limited to case management, mental health support, and referral to longer-term community services. Referral and follow-up services to inpatient and outpatient mental health services and/or other services in the community in a manner that ensures there is continuity of care. Access to short-term inpatient crisis beds or community-based crisis intervention beds in service areas that have these resources; and, where appropriate, follow-up contact with the child's DCF Social Worker to maintain joint treatment planning.

Capability and orientation to respond to all children and youth in crisis, including substance-abusing youth who are in severe emotional crisis (e.g., suicidal, psychotic, homicidal) and where appropriate, engagement and follow-up contact with various mental health facilities to establish discharge plans from inpatient or follow-up upon discharge from the EMS service.

k. "Seriously Emotionally Disturbed (SED)"

Children or adolescents who are Seriously Emotionally Disturbed" (SED) are children from age birth to eighteen years and currently or at any time in the past year had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV; and resulted in a functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities;

Children are not identified as SED however, if doing so is based solely on DSM-IV diagnostic "V" codes, substance use, or developmental disorders.

l. "Stabilization"

The time-period of up to six weeks that follow the initial clinical assessment is the "stabilization phase" of the intervention. During this time the EMS staff offers support, clinical interventions, referrals to traditional and non-traditional services, and concrete suggestions and problem solving. Typically, stabilization services are offered until the child/youth is connected to ongoing care and/or community supports.

Although EMS interventions are therapeutic in nature, and the clinicians address the salient symptoms and stressors, The EMS staff should not function as ongoing therapists for the child/youth.

m. "Discontinuation from Service"

Services are discontinued when the child has been clinically stabilized, no longer presents a risk, and - if required by the child's emotional and behavioral functioning – when the child is enrolled on follow-along care. When follow-along services are indicated, EMS services should not be discontinued until a clinician at another site is seeing the child.

n. "Parent Preference"

In situations when the crisis requires in-person intervention by the clinician(s), the preference of the parent or guardian takes priority as to the location. Clinicians will do everything to engage the family and meet them at the family's residence, if that is their preference.

o. "Service Coordination/Case Management"

A service involving direct client contact which provides the availability of an accountable individual to serve as an advocate, helper, service broker, and liaison on behalf of a child and his/her family for coordinating service components. Services are provided to children in the care of DCF as well as children in the State who are identified with a Serious Emotional Disturbance (SED) to ensure the elements of treatment, domicile, and supportive services are planned and provided.

p. "System of Care"

A comprehensive spectrum of mental health and other support services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbances and their families. The creation of such System of Care involves a multi-agency, public/private approach to delivering services, an array of service options, and flexibility to meet the full range of needs of children, and their families. Mechanisms for managing, coordinating, and funding services are necessary.

q. "Levels of Care Coordination"

- *Level I*: When a child is involved in only one service component, the child's service provider or a member of the multidisciplinary team assigned to the child is responsible for care management in partnership with the family.
- *Level II*: When a child has a DCF worker, the child's worker serves as the care coordinator collaborating with the child's primary service provider or with a member of the assigned multidisciplinary team.
- *Level III*: When a child is involved with several agencies and is identified as needing care management independent of any particular service received, care coordination may be performed either by the DCF caseworker in conjunction with a full-time care coordinator provided through the System of Care or, in situations with no DCF involvement, exclusively by a care coordinator. Such care coordinators have a small caseload—typically eight to twelve active cases at any given time and thirty-six in the course of a year. In cases where a DCF Social Worker and a care coordinator are both involved, the care coordinator will take the lead.

r. "Child Specific Team" (CST)

This is a small group of people requested by the parent or caregiver to help develop and implement a comprehensive, creative, and individualized service plan for a child. CSTs are developed by the parents with advice from a Care Coordinator and a family advocate. A team may typically include members of the child's extended family, clergy, and informal helpers, as well as selected professionals.

s. "Interagency Management Team" (IMT)

This is leadership group in a service area that includes parents of children with SED, family advocates, at least one mental health clinician, and high-ranking agency administrators. The IMT functions to establish interagency agreements, identification of local needs and barriers, creation of new services, assess effectiveness of the CST's and CRC, and most importantly, serves as a steering committee for the local community concerning children's behavioral health services.

THE PROGRAM

Governing Body

The Governing Body for all KidCare services is the Connecticut Behavioral Health Partnership. Each EMS program's corporate structure, e.g., Board of Directors, serves as its own Governing Body. In addition, the local system of care serves an important advisory role to each EMS program.

Program Requirements and Services

These are listed under "Clinical Intervention" (above), which are consistent with the current standard core contract, Part III, for EMS.

Reporting Requirements

These are more fully addressed in the Quality Assurance section of this document. Essentially, each provider maintains a database consistent with the "Behavioral Health Data Base" which specifies numerous fields of information. Each provider agency should maintain its own database for internal program management and assurance purposes. The KidCare Governing Body envisioned the need for ongoing, internal quality assurance and built in the position of "Service Effectiveness Coordinator" to each program for this purpose. That individual works closely with the program's Clinical Director and staff for internal quality assurance, coordinates routine reporting to DCF, responds to *ad hoc* data requests from DCF, coordinates or administers consumer satisfaction surveys, and tracks response times to calls from consumers. Each program shall have its own quality assurance plan that shall be available for review.

Staff Qualifications

In selecting all staff, equal emphasis shall be placed upon cultural diversity, community-based family-focused experience, and bilingual skills as on clinical expertise. The qualifications of EMS staff shall be as follows:

Clinical Director

The Clinical Director of EMS shall have, at a minimum, a master's degree in social work, psychology, or marriage and family therapy, or a Ph.D. in psychology. The Clinical Director shall be licensed by the State of Connecticut and possess at least five years of experience in the provision of mental health services, with at least two of those years in an administrative position. The Clinical Director shall have the ability to take

initiative to evaluate clinical and administrative situations as they arise, to develop an action plan to address such situations, and to take the necessary steps (in consultation with the Chief Executive of the clinic in which the EMS program is based) to ensure that the action plan is implemented and functioning. This individual will also have experience and ability in training and supervision of professional staff.

EMS Clinician

The EMS clinicians shall have, at a minimum, a master's degree in social work, psychology, marriage and family therapy, psychiatric nursing, or other related human service field. The EMS clinicians should have experience in the provision of crisis services for children and adolescents, preferably on a mobile basis. The EMS clinicians must be: able to travel with their own car to all areas within the designated catchment area; willing to make mobile visits to homes, schools, and other sites where their services may be required; able to work effectively under pressure and with intense emotional situations; and able to work with a team in a cooperative and collaborative manner.

Psychiatrist or Advanced Practice Nurse Practitioner (APRN)

The EMS psychiatrist will be a fully licensed psychiatrist, preferably board certified in child/adolescent psychiatry, with experience in the provision of urgent psychiatric assessment and care of children and adolescents, and with expertise in medicating psychiatric disorders of childhood and adolescence. In some programs, medication evaluations and med checks may be conducted by a licensed APRN, who will be supervised by a licensed child/adolescent psychiatrist.

Comprehensive Care Manager

The EMPS Comprehensive Care Manager must possess a Bachelor's degree in social work or other relevant human services field, plus experience and training in working intensively with high-risk families. This individual must be willing to provide mobile services (utilizing his/her own car) to families in the catchment area. In addition, the Comprehensive Care Manager must possess knowledge about child development and parenting, and be culturally competent in working with diverse populations. He or she must also have the ability to relate to, and engage with, children and parents, to work collaboratively as a team with other staff, and to interact effectively with other agencies.

Service Effectiveness Coordinator

The Service Effectiveness Coordinator must possess at a minimum a Bachelor's Degree in a human services field and/or data collection, management, and analysis.

This individual must demonstrate competency in computerized data base administration, be able to interpret data, conduct record reviews, and to work collaboratively with DCF and other agencies on quality assurance, evaluation, and other data reporting efforts.

Role of the Clinical Director

The Clinical Director is responsible for the overall operations of the EMS program. The role of the Clinical Director includes the following: providing administrative and programmatic oversight of the EMS program; promoting knowledge and full utilization of the EMS program within the community it serves; ensuring adequate staffing and supervision of personnel for mental health services under EMS; and providing clinical services to clients when necessary and appropriate. More specifically, the Clinical Director is responsible for program design and planning, recruiting and hiring of all EMS personnel, development and implementation of appropriate training programs for personnel; developing working relationships with other community agencies; supervising the activities of all other EMS personnel; developing appropriate protocols, policies and forms for use by the EMS program; completing or supervising the completion of all appropriate reporting forms to DCF and other involved supervisory agencies; ensuring that EMS meets all requirements and policies to which it is committed; dealing with problems and critical incidents involving EMS staff and services; developing and monitoring appropriate quality assurance measures and programs; ensuring that identified problems are being addressed with effective measures to improve quality and effectiveness; coordinating activities with the Care Coordination program; conducting regular meetings with all staff to address issues and to provide supervision and direction; conducting direct clinical services when necessary and appropriate; ensuring that the services of the EMS Program are culturally competent and respectful of the input and preferences of the families; assisting in contract renewal and development of quarterly contract reports to DCF; reporting directly to the Chief Executive of the contract-holding agency, and performing such other duties as may be designated by the Chief Executive.

In situations where the EMS provider subcontracts the provision of significant aspects of EMS services for a service area, the Clinical Director may delegate any of the afore-mentioned responsibilities to the sub-contractor.

Staff Development

The Clinical Director of EMS, in conjunction with any subcontractors, will ensure that all EMPS employed by KidCare provider agencies are adequately trained and educated to perform their duties effectively and safely.

It is the responsibility of each participating agency to educate their staff in the areas of mandated reporting, blood borne pathogens, and crisis management techniques prior to

providing direct services to children. Ongoing education of staff and clients and training of EMS staff will be provided as needs are identified through supervision, staff requests, and program experience. The topics of cultural competency, suicide prevention, and de-escalation strategies will be emphasized with all staff.

The Clinical Director will organize ongoing trainings to all direct service staff in addition to the topics mentioned above. Below are suggested topics of which staff should have some working knowledge.

- *Family Systems*
- *Non-Traditional Therapies*
- *Contracting for Safety*
- *Sexual and Physical Abuse*
- *Substance Abuse/Dual Diagnosis*
- *Secondary Trauma to Staff*
- *Interviewing Techniques*
- *Crisis Theory*
- *Special Education*
- *Basic Psychopharmacology*
- *Documentation*
- *Effective Brief Treatment*
- *Strength-based Service Planning*

Staff development is an ongoing process, and it is the responsibility of the agencies, management and the individual clinicians to keep abreast of current trends and new information relevant to the services provided. Therefore training topics may be revised, repeated, or amended according to the needs of the staff and the communities served.

Program Elements and Parameters of Operation

Accessibility

Emergency Mobile Services will be available by telephone 24 hours a day, 7 days a week. The hours of mobile capacity are determined based on the contract with DCF. The contracted hours of mobile capacity, at a minimum, are 10:00 a.m. – 7:00 p.m. Monday through Friday and 1:00 p.m. – 7:00 p.m. on Saturdays, Sundays, and holidays.

Immediate access to care is the guiding principle of EMS. Programs will utilize a well-publicized toll free number that will accept referrals and provide triage services 24 hours a day, 7 days a week for 365 days per year. All referrals to the EMS Team will be responded to by telephone within 15 minutes.

During hours of operation, EMS programs should provide direct service to clients in their homes and/or community whenever possible. The location of the service should be determined based on the family's needs and preferences. In situations where the safety of either the client or the EMS Team is in question, the location for the service should be negotiated with the parent/referral source.

Response Times

It should take no longer than 15 minutes for a clinician to intervene by telephone if a caller needs a clinician (i.e., not just information and referral).

The outcome of the initial contact from the EMS team determines the response that is clinically appropriate, and therefore, the response time. If the decision is made to make immediate face-to-face contact with the client, the EMS team will work with the referring party to determine the best place to meet; and the goal is to make face-to-face contact within 30 minutes of the initial telephone contact. Factors such as geographic area, family preferences, and weather will affect the response time. Should the decision be made to schedule an appointment to meet at a later time, the goal is to make face-to-face contact via the appointment within 24 – 48 hours.

Mobile capacity is an essential requirement of EMS. The work of EMS is performed in the least restrictive and safest environment and should always take into account the preferences/needs of the family requesting assistance. These services are established to allow local systems of care to have emergency response capability for children and adolescents not already engaged in behavioral health clinical services and are experiencing serious emotional or behavioral problems. The expectation for serving children who are already engaged in behavioral health clinical services is that the community outpatient behavioral health provider will provide an emergency on-call

system to support the family being served. In those cases where the child and family requires additional support to that provided by their treatment provider, EMS may offer consultation or enhancement services including mobile services. All efforts should be made in advance to be educated about the child's treatment plan and clinical recommendations to assure continuity of care. EMS can negotiate to provide on-call services for community providers if additional funding is secured to cover that services.

After Hours Coverage

Programs are expected to be available by telephone 24 hours a day, seven days a week. A clinician needs to be available to guide the family to a disposition that will keep the child safe until the next day when an in-person clinical appointment can be arranged with EMS staff.

In situations where after hours telephone service is sub-contracted, programs may need to provide training to the subcontractor's staff for proper triaging and decision-making.

If there is a crisis after 7:00 p.m., the telephone clinical intervention should produce a safety plan, immediate referral if necessary, and follow-up arrangements with EMS. Also, programs may provide additional hours of mobile capacity, e.g. beyond 7:00 p.m., at their discretion.

Transporting

When a child needs to be transported to another site for treatment, the preferred practice is for the family or EMS team to transport the child if doing so is consistent with the provider agency's policies and the child's clinical presentation. Otherwise, the EMS clinician(s) can encourage parents to find these resources. There may be circumstances in which ambulances are necessary, but *ambulances shall not be used as a routine means of transporting children in crisis to other treatment sites.*

Use of Restraints

Children and/or others in a household may exhibit behaviors or verbalize intentions that could be of immediate danger to themselves or others. In many situations, EMS clinicians will be able to assess danger on the phone and engage police or other public safety personnel if there is a life-threatening situation. However, there may be situations when a decision is made to make an in-person assessment in an unstructured, unprotected environment, such as a family residence, and dangerous behaviors are exhibited or dangerous intent is verbalized. Emergency mobile services clinicians must respond in such situations with quick, but very sound, clinical judgment. EMS practice in KidCare is to engage police or other public safety personnel immediately and not to administer restraints. Moreover, the use of mechanical or psychopharmacological restraints is strictly prohibited. EMS programs should develop

their own procedures to address behavior management issues by utilizing verbal de-escalation interventions and defining under what circumstances police should be called.

Child and Family Rights

Parental Consent

In general, parental consent is required before services can be provided to a minor child. There are some exceptions to this requirement, such as an acute life-threatening emergency and situations in which a mature minor seeks treatment without consent of a parent or guardian in accordance with Public Act #92-129.

Assessment

The crisis evaluation is a comprehensive bio-psycho-social assessment as it relates to the child's presenting symptoms and history in a family context. The evaluation is comprised of information including identifying information/demographics, a suicidality/safety assessment, the presenting problem by client self-report and family/caregiver concerns, collateral information, brief psychosocial history, cognitive functioning, educational status, medical history, substance abuse, social/cultural aspects of the child's environment, familial strengths/resources, mental status, DSM-IV diagnostic impression, formulation and initial service plan and recommendations. Evaluations are conducted in a child-centered, family focused method, which incorporates the input and opinions of parents and/or significant caregivers.

Treatment/Service Approach

EMS programs provide direct service to clients in the home, school, hospital setting, or community at large. The location and preference of the initial face-to-face visit is assessed based on the child and family's needs. Safety issues may be of concern, and the clinician may arrange a neutral setting. The treatment approach should be implemented in a manner that is child centered, family focused, community-based, culturally sensitive, and strength based.

Treatment should focus on stabilization of the crisis and brief intervention.

The response to the initial call from a parent or referral source will generally fall into one of four categories: Emergency situation, Urgent situation, Non-urgent situation, or an Information/referral situation where parent could be seeking advice. For the first three situations, the initial contact should focus on assessment, crisis intervention, safety planning and identification and subsequently stabilization services. Subsequent

sessions may include advocacy, individual and family sessions, psycho-education, case management, school consultation, psychiatric consultation, and/or medication management.

The response to each crisis call received is based on clinically driven decisions made by the EMS Team. Depending on the structure of the program, and the time the call is made, the response will either be immediate or an EMS Team member will respond to the caller within the 15-minute timeframe

Primary goals of the intervention are to divert general hospital Emergency Department (ED) admissions when clinically appropriate; stabilize the child in crisis; support the family system; and link with appropriate traditional and non-traditional resources. However, in some instances hospitalization will be necessary.

The brief treatment phase or "maintenance" is the period when the child and family receive short term in-home or community follow-up services. The intervention consists of building on the family's strengths and supports. The crisis plan is developed between the clinician and family to meet the immediate need until ongoing services can be arranged. The duration of EMS is anticipated to be up to approximately six weeks.

Some children will require continued treatment once the brief phase has ended. These cases should be transferred to an appropriate level of care. It is helpful to start the process immediately after engagement with the client. Discharge is a clinical judgment call based on resolution of the crisis.

Each EMS program will develop clinical decision-making protocols to assist the EMS staff and the community with the decision-making process.

Triage with Emergency Departments

The EMS programs will work to establish a strong link with hospital emergency departments in their respective service area(s). As necessary, the crisis program will refer severe risk cases to an area emergency room. The ED will receive referrals from the EMS that have been assessed by the crisis team and found to warrant emergency department assessment for psychiatric hospitalization. Crisis staff will notify the ED of the anticipated arrival time and provide relevant clinical information. In addition, when a child is evaluated in the ED and determined to not be in need of hospitalization, the EMS program may be available to provide follow-up assessment, stabilization services, and short-term intervention.

Discharge or Step-Down Service Criteria

Discharge from Emergency Mobile Services will be based on clinical decisions and the needed level of care:

- *highly acute*- clients who are designated viewed as dangerously and imminently violent, psychotic, or suicidal will be discharged to an inpatient or residential facility in the care of a psychiatrist.
- *subacute* - clients with complex behavioral health needs and significant risk factors who do not require hospitalization may be discharged to appropriate combinations of services such as Partial Hospitalization, intensive in-home clinical services, extended day treatment or "sub-acute" units in hospitals or freestanding facilities. They will also have a referral to Care Coordination.
- *outpatient level of care*- clients who can be maintained with weekly outpatient therapy should be discharged to an appropriate local clinic or therapist of the family's choice. An appointment must be in place and releases signed to the outpatient service for discharge to take place. This must be reflected in the case notes.

All discharges must reflect either successful stabilization of a crisis or discharge to a specific set of services in a different level of care. A crisis plan and discharge plan must be in the chart and signed by the clinician and the family, except in phone contact only situations. If a family chooses to discontinue the EMS service prior to the close of treatment and against the advise of the EMS clinician, this should be noted in the case notes as well as what level of care was recommended. If possible the family will sign a release indicating that they are terminating against the advice of the EMS clinician. The clinician then must state in the case notes what the risk is to the child. If the risk is imminent the EMS clinician must act immediately to seek appropriate services such as DCF, existing providers, and/or the police.

All discharges must reflect linkages with community organizations, care coordination, or non-traditional providers, whichever are appropriate to the child and family, unless these are unnecessary or not desired by the family. Children requiring follow-along clinical treatment should not be discharged until they are actually enrolled in the next level of care. Note: *referrals alone to ongoing care are not sufficient to close a case in which the child requires ongoing treatment.*

Discharge plans must reflect the services provided, progress made, current mental status, prognosis, target date or confirmed date of behavioral health appointment, and linkages provided.

Role of the Comprehensive Case Manager

The Comprehensive Case Manager (CCM) shall be the EMS program's expert on community resources. He or she should have lists of both traditional and non-traditional services within the community, and should serve as the link among the family, the service provider, and Care Coordinators or EMS clinician, and assist EMS families in obtaining services. While a child is enrolled in EMS, the CCM shall provide all case management and coordination services but, at discharge, certain cases meeting "Level III" criteria will be picked up by care coordinators. If a child is receiving EMS is already enrolled in care coordination, then the CCM and care coordinator will collaborate either by communicating with the Supervisor of care coordinators or directly with the care coordinator.

The Comprehensive Case Manager will take Level I and II case referrals for case coordination services (i.e., cases not meeting criteria for care coordination) and establish and maintain contact with any DCF worker involved.

Additionally, the CCM should attend Child Specific Team meetings to be part of planning for the child and family receiving care coordination assuming the family wishes this involvement from EMS in developing an ongoing service plan. The role of the CCM in those meetings is to be able to offer links to the community to the child and family.

The Comprehensive Case Manager may accompany clinicians on follow-up appointments to be sure that families are aware of other services in their communities.

The Comprehensive Care Managers should be available to the EMS clinicians and care coordinators to assist in suggesting and locating services for families.

Linkages and Agreements

Linkages

Emergency Mobile Services work closely with Care Coordinators, Emergency Departments, local police, schools and other health and human service agencies to continuously improve means to communicate, respond efficiently to crises, and define the responsibilities of all parties. Collaborative relationships with other agencies will be developed i.e. Child Guidance Clinics, school systems, Youth Service Bureaus, Park and Recreation Departments, pediatrician's inpatient and partial hospitalization programs, parent support groups, and substance abuse treatment. Because collaboration with police, schools, general hospitals, and child guidance clinics is so crucial, frequent, and sometimes challenging, the following three sections address those areas.

Working with the Police

The Emergency Mobile Service providers shall attempt to develop collaborative relationships with all local police agencies, emergency medical technicians, and local fire and rescue units within their region. Ideally, these working relationships will specify with clarity the respective roles of police and EMS clinicians. EMS programs shall endeavor to help police understand how EMS can be of assistance to them and the citizens that each serve; and EMS programs shall help police understand how the police can be most helpful to the EMS program. One example is for the EMS and police to avoid unnecessary use of hospital emergency departments.
All efforts must be made to avoid the arrest of a child who, by reason of emotional and behavioral disabilities, is in the position of "acting out." When the issues are not criminal in nature but are primarily emotional or related to behavioral health disorders.

Working with Schools

The EMS shall attempt to develop Memoranda of Understanding with the local education authorities in their region to set forth the protocols involved in possible emergency services. Schools shall be asked to distinguish the appropriate role of EMS intervening in true crisis situations *versus* the resolution of a "zero tolerance" issue. Depending on local arrangements, EMS providers are permitted by DCF to contract with schools to provide additional support or take the place of psychological/clinical services that schools are expected to provide themselves for evaluations of students. The contractual obligation with DCF is to do emergency assessments. This will include evidence of appropriate assessment of the child's potential for behaviors that would necessitate EMS. This information should be shared at the annual Planning and Placement team meeting. Written permission for EMS to intervene, if required, should then be sought from the parent/guardian, while at the meeting. Included on that signed document should be the protocol for emergency services for the school's action. This would include a commitment to the parent/guardian that that person will also be contacted immediately in the event of an emergency.

Services above and beyond the DCF contractual obligation can be negotiated with the schools.

Working with General Hospitals and Child Guidance Clinics

EMS will attempt to establish memoranda of understanding with local general hospital EDs that describe the interface of both services. EMS will also develop Memoranda with local Child Guidance Clinics to accept urgent outpatient referrals for youth that are seen by EMS. EMS will also participate actively in local Community Collaboratives and provide a leadership role. EMS will work closely with care coordinators from the Collaborative to provide a seamless service delivery for youth and their families. Gaps in services and systems barriers noted by EMS will be brought to the attention of the local Community Collaborative.

Gatekeeping

EMS Programs shall be the gatekeepers for Crisis Stabilization beds in their region if those resources have been developed in the respective region. All referrals for the crisis beds must go through EMS and EMS will assist in discharge planning.

In the case of referrals that are inappropriate or questionable the Clinical Director will make the determination if the case is appropriate or needs to be referred to a different agency.

Referrals Across Service Areas

When a parent, guardian, or child calls an EMS provider that does not cover the geographical area in which the person requesting help is located, the EMS provider receiving a call shall make every effort to connect the client with the EMS provider designated to serve the area where the caller is located. The situation should be assessed to determine if the caller is "at risk" or in imminent danger and, if so, address the situation immediately and then call the local provider to communicate what has transpired in the contact with the initial EMS program (i.e., the EMS program out of the caller's area). If the caller is able to access the crisis service on their own they should be instructed to call back if they are have difficulties at which time the EMS provider shall intervene.

EMS shall make referrals to Care Coordination in the case of any Level III clients that EMS is called to serve.

In the case that a client is DCF involved the EMS clinician shall call the DCF worker to report the contact and assist in referrals for the client.

The Comprehensive Case Manager shall assist the family in accessing services of extended day programs, intensive in home services, respite, and therapeutic mentors when appropriate.

Community Collaborative Participation

A clinically knowledgeable program administrator from each EMS program will participate in systems of care served by the EMS program including, if applicable, Interagency Management Team and Community Resource Committee meetings. EMS clinicians will participate in case specific System of Care meetings regarding their patients assuming parental preference for their participation.

QUALITY ASSURANCE

Continuous Quality Improvement

As the Behavioral Health Partnership designed the program structures for Emergency Mobile Services and Care Coordination, the group faced a significant concern for accurate data collection and reporting as well as comprehensive quality management activities around these programs. The function of the Service Effectiveness Coordinator was mandated by the Partnership for the purpose of assuring that this concern was addressed. *Service Effectiveness Coordinators, or other persons carrying out this quality management function, serve a prominent role in the execution of contractual obligations by the agency.*

The Service Effectiveness Coordinator's position should be reflected on the agency's organization chart so that parties understand where the position fits within the agency's structure and that placement of the position within the organization chart reflects the quality assurance nature of the responsibilities. *It is also important for agencies to provide the Service Effectiveness Coordinator with the authority and power to obtain required information from both agency and sub-contractor employees in order to coordinate an on-going path of communication of all process and procedure developments.*

As the Service Effectiveness Coordinator is responsible for collaborating and reporting to numerous internal and external entities including but not limited to his or her own agency, DCF, DCF evaluators, families, collaboratives, and other community groups, it is important that personnel of contracting and sub-contracting agencies fully understand the responsibilities of the Service Effectiveness Coordinator position.

Role and Function of the Service Effectiveness Coordinator

The role of the Service Effectiveness Coordinator is to serve as a quality assurance (QA) resource and liaison for both the EMS and Care Coordination programs and staff. Per contractual requirements, this position is responsible for the following[**]:

- Submitting accurate data required by DCF in a timely manner.
- Measuring and assessing how the performance and implementation of services impacts outcomes for children and families.
- In concert with DCF, assuring a significant, objective focus on consumer feedback, i.e. satisfaction interviews and surveys.

[**] In some programs, with the permission of DCF, the roles and functions of the Service Effectiveness coordinator are performed by more than one person.

- Assuring the provision of a quarterly report or written feedback to families, collaboratives, community providers, and DCF regarding the process steps and outcome targets.
- Participating with DCF in the implementation of a process where there is an inclusive review of performance data in order to inform and improve direct practice, management, and support services.
- Assisting DCF in data infrastructure development projects as they relate to crisis and care coordination services.
- Participating in agency and community activities (i.e.: meetings, workgroups) related to the development and implementation of data reports including but not limited to: methods of collection, aggregation, dissemination, and format of reports.
- Providing on-going review of quality and effectiveness of both EMS and Care Coordination programs Developing inclusive process to inform practices and decision-making regarding EMS and Care Coordination programs.
- Providing assistance to DCF evaluators and coordinating agency responses to evaluation requirements.
- Facilitating Community Collaborative development and expansion by assisting in network development, committee participation, community relations, increasing parent involvement, and arranging for and providing training and technical assistance as appropriate.
- Assuring that regular chart audits are conducted including reviews of crisis plans, treatment plans, and progress notes.
- . The audit should review the completeness and quality of the record keeping.
- Tracking response times as required by DCF.

Given the evolving nature of EMS, there should be an annual review of the role and function of the Service Effectiveness Coordinator to assure that agencies and DCF have a common understanding of this critical position.

The Service Effectiveness Coordinator should be involved in the collection of data regarding caseload trends and management issues (i.e. ethnicity representation, average number of visits, missed appointments, acuity level, etc.).

Quality Assurance for Continuity of Care

It is expected that all clients whose level of acuity warrants a lower level of care are referred to a lower level of care and have an initial appointment within 7 days discharge from EMS or are clinically followed by EMS until the client is stabilized or successfully connected to ongoing treatment. A quality indicator for this work is as follows: A chart audit indicates that 90% of clients requiring a lower level of care are successfully linked to services.

A second quality indicator for continuity of care is that: EMS clinicians or Comprehensive Care Managers participate in Child Specific Team meetings in 90% of

the cases in which the family invites them. If they are unable to attend they ensure that EMS materials are sent to the family.

A third quality indicator for continuity of care is: the Comprehensive Care Manager keeps a list of Community Resources, which may be handed out to families, or EMS clinicians to take to clients.

Finally, all calls or visits from EMS will be followed up by EMS with a call or visit to the client as the discharge plan is developed for each child and family. It indicates future

- clinical treatment and linkages to community organizations, traditional as well as non-traditional.
- The client record reflects and report to DCF reflects that appropriate outpatient, partial, intensive-in-home, or extended day services are in place prior to discharge from EMS. If the client is involved DCF the worker has been contacted.
- 85% of children meeting eligibility requirements for Level III Care Coordination receive that service in local Community Collaborative at the closure of their case. The family should be advised that if the situation destabilizes that they might re-contact EMS.

Elements of the Clinical Record

Clinical records related to EMS should include following items:

- Notes from the initial call
- Assessment/Intake Form including:
  - Mental Status
  - Recent/Current Treatment
  - Medical/Clinical Treatment History
  - Persons Present at Assessment
  - Presenting Crisis Information
- Current Medications List Indicating Compliance/Non-Compliance
- Diagnosis Axis I-V
- Education History/Status (grade, school, special ed, and attendance)
- Legal History
- Family Psychiatric History
- Access to Weapons/Objects to Harm Self or Others
- Identification of Child/Family Strengths and Supports
- Child/Adolescent's Substance Use History
- Family's Substance Use History
- Trauma History
- DCF Involvement
- Collateral Contacts
- Disruption in Family History/Placement

- Risk Assessment
    - Clinical Assessment and Formulation
    - Crisis Plan
    - Initial Service Goals/Disposition
    - Cultural Factors
    - Safety Contract
    - Treatment Plan
    - Progress Notes
    - Initial and Discharge Ohio Scales (when appropriate)
    - Release of Information for DCF
    - Other appropriate releases
    - Discharge Summary including referrals made

Other Points:

It is imperative that age appropriate assessment tools be used.

Providers should consider a style of writing progress notes that captures what service was provided, activity performed and/or what future action is necessary as opposed to using a journaling style. S O A P notes (Say, Observe, Assessment Plan) or DAP (Data, Assessment, Plan) are examples of such styles.

Other information that may be helpful to the EMS team and should be collected and included in the record as needed may include school evaluations, other documentation obtained, etc.

Admission/Discharge Documentation

Documentation should include but not be limited to the following: OHIO scales Problem Severity Index- Parent perspective, a welcome packet of information for families that introduces them to services, contact information, client's rights and grievance procedures, consent and release forms.

Outcomes

At this time, DCF's outcome measurements for this program are being derived from client satisfaction surveys and the OHIO scales parent version of the problem severity scale (short form). The expectation with the OHIO scales is that when three or more face-to-face interventions are necessary that 75% will have completed an initial administration of the Parent perspective of the Ohio Scales *Problem Severity Index.*

There is an identified need to collect outcome data information, such as a satisfaction survey, from constituencies other than the child and family. Schools, emergency room

personnel, and other social service professionals may contribute important information for improving services.

Future outcome considerations should include diversions from emergency room visits, hospital admissions, and/or police interventions.

Community Education

Each EMS will develop and implement an ongoing community education and marketing initiative regarding EMS and Care Coordination services. This multi-pronged community outreach and education initiative will include, but not be limited to:

- *parents*
- *family advocates and advocacy groups*
- *community service programs including homeless shelters and soup kitchens*
- *pediatric care providers*
- *early intervention programs (child wellness, Birth to Three, Head Start)*
- *faith-based organizations*
- *community collaboratives*
- *emergency departments and other pertinent departments in local hospitals*
- *schools and school-based public health clinics*
- *community behavioral health providers*
- *juvenile court*
- *police departments*
- *local offices or mental health authorities, DCF, DMR, DMHAS, DSS*

Specific service information will be available in multiple media including hardcopy fact sheets, brochures, and web-based technology. These materials will be available in languages appropriate to the population served.